DEPARTMENT OF MANAGED HEALTH CARE

INITIAL STATEMENT OF REASONS

Standard Dental Benefit and Coverage Matrix
Title 28, Section 1300.63.4

(Control No. 2020-DEN)

Pursuant to Government Code section 11346.2, the Director of the Department of Managed Health Care (Department) submits this Initial Statement of Reasons in support of the proposed adoption of section 1300.63.4, in title 28 of the California Code of Regulations (CCR). Section 1300.64.4 was adopted on December 29, 2020 as an Emergency File and Print regulation, became effective on January 25, 2021, and will remain in effect until September 25, 2021. The Department proposes to adopt those regulations with some changes, which are noted in underline and strikeout. The Department is incorporating by reference the Emergency File and Print rulemaking file (File No: 2021-0115-01EFP.)

I. DEPARTMENT'S AUTHORITY

Health and Safety Code section 1344 grants the Director the authority to adopt, amend, and rescind such rules, forms, and orders as are necessary to carry out the provisions of the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act).

Health and Safety Code section 1363.04 mandates health plans and dental plans utilize a uniform benefits and coverage disclosure matrix, which shall be developed by the Department.

Brief Procedural History

The Department developed the regulation text, the uniform benefits and coverage disclosure matrix, hereinafter the Summary of Dental Benefits and Coverage (SDBC). and the Instruction Guide for Summary of Dental Benefits and Coverage Disclosure Matrix (Instruction Guide) in conjunction with the California Department of Insurance (CDI) and also consulted with stakeholders, as required by Health and Safety Code section 1363.04. [1]

The Department adopted the emergency regulation as a File and Print emergency regulation on December 29, 2020. The Department provided the public with a 5-day

[1] The DMHC protects consumers' health care rights and ensures a stable health care delivery system. As part of this mission, the DMHC licenses and regulates health plans under the Knox-Keene Act. The DMHC regulates the majority of health care coverage in California including 95 percent of commercial and government health plan enrollment. Health plans licensed by the DMHC provide coverage to more than 27.7 million enrollees.

Notice of Rulemaking action on December 30, 2012. [2] The emergency regulation became effective January 25, 2021 and expires on September 25, 2021.[3]

Amendments to Emergency Regulations

This rulemaking action proposes to adopt the emergency regulation as a final regulation. The Department is adopting the emergency regulation with some modifications, which are listed below and described in the applicable subdivisions below.
The proposed regulation adopts the emergency regulation and does the following:

Revises the regulation text, section 1300.63.4 as follows:

- Amend subdivision (a)(1) by establishing the compliance date of on or after January 1, 2022;
- Amend subdivision (b)(1) to correct a typographical error in a cross-referenced citation;
- Amend subdivision (c) to correct an error in the subject of the regulation;
- Amend subdivision (c)(1) to revise the dates of the two incorporated documents, Summary of Dental Benefits and Coverage Disclosure Matrix, and the Instruction Guide for Summary of Dental Benefits and Coverage Disclosure Matrix;
- Amend subdivision (c)(3) to specify the date by which health care service plans and specialized health care service plans must affirm to the Department compliance with the proposed regulation;
- Amend subdivision (d)(1)(E)3. by making a nonsubstantive grammatical change;
- Amend subdivision (d)(1)(E)3.d. to replace a reference to the group with a reference to the enrollee;
- Amend subdivision (d)(2)(B) to insert a word that was inadvertently omitted;
- Amend subdivision (d)(2)(D)3. by making a nonsubstantive, grammatical change;
- Amend subdivision (d)(2)(D)(3)(c.) for consistency with a previous reference to federal and state law in the text;
- Amend subdivision (d)(3)(E)3. to clarify the group contractholder's required website delivery method of the SDBC; and
- Amend subdivision (j) to insert a reference to the code in which the section of law is found.

Modifies the two incorporated documents, the Instruction Guide and SDBC, by

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[2] Health & Saf. Code § 1363.04(f)(1) and (2) mandate the Department to adopt emergency regulations that shall be deemed an emergency and provides that they are not subject to the review and approval of the Office of Administrative Law.
[3] Because of the COVID-19 pandemic's impact on statutory deadlines, Governor Newsom signed and issued Executive Order N-40-20 (March 30, 2020) and Executive Order N-71-20 (June 30, 2020) which, among other things, had the effect of extending the effective date of the emergency regulations by a total of 120 days.

revising the dates of the documents.

Revises the Instruction Guide for Summary of Dental Benefits and Coverage Disclosure Matrix as follows:

- Amend Part II to clarify the information to be included in the Summary of Dental Benefits and Coverage Disclosure Matrix;
- Amend Part III to add a fourth option, which is to enter a dollar amount; and
- Amend Part V to revise the description of three of the listed dental services.

Revises the SDBC as follows:

- Remove the Department logo; remove the identifying information from the header and substitute a footnote with identifying information;
- Amend Part III to clarify the information to be included and to add an option to enter a dollar amount;
- Amend Part V to revise the description of two of the listed dental procedures;
- Amend Part VI to revise the dollar amounts in the Coverage Example, Total Cost of Care; and
- Amend Part VI to add an option to enter a dollar amount for the out-of-network maximum

II. Specific Problems Addressed, and Necessity of Regulations

Background

The federal Patient Protection and Affordable Care Act (ACA) and regulations implementing the ACA require medical insurance companies to utilize a uniform "summary of benefits and coverage" (SBC) template, which describes benefits in plain language and allows consumers to easily compare different health plans for what services are covered, what the enrollee will have to pay in cost-sharing, and what limitations and exclusion provisions apply to receiving certain medical benefits.[4] The federal regulation implementing the ACA requires health insurers or health plans to provide individuals clear, consistent, and comparable information about health plan benefits and coverage in a template provided by the federal government. However, this consumer protection and transparency requirement does not apply to dental health plans or dental insurance plans.

In 2018, the California legislature enacted Senate Bill 1008 to promote transparency in dental benefit coverage by requiring the Department and the California Department of Insurance (CDI) to create a uniform summary of dental health benefits matrix for easy

[4] 45 C.F.R. §147.200 ("federal SBC regulation.") The federal government has issued guidance for implementing the federal SBC regulation consisting in part of: SBC Template Standard Format, Summary of Benefits and Coverage Completed Example, Summary of Benefits and Coverage Instruction Guide for Individual Health Insurance Coverage, and Summary of Benefits Instruction Guide for Group Coverage ("SBC Guidance Documents"). The SBC Guidance Documents and the federal SBC regulation are collectively referred to herein as "federal SBC requirements."

access to clear and comparable dental health benefits for dental health plan enrollees and consumers.[5] In enacting SB 1008, the legislature's goal is to provide consumers with comparable information about dental insurance from all dental carriers offering coverage.[6] According to a statement from the author in the legislative history of SB 1008: "Currently, there is no standardized benefit reporting form, like that which exists for medical insurance. Benefits information may be spread through long documents that make it difficult for consumers to compare plans. This bill requires disclosures and standardized benefit reporting to help consumers understand what they are purchasing." (Sen. Rules Com., Off. Of Sen. Floor Analyses, unfinished business analysis of Sen. Bill No. 1008 (2017-18 Reg. Sess.) as amended on August 23, 2018, pg. 4-5.) For example, a consumer should have transparent access to information describing what a particular dental plan covers and what the consumer can expect to pay for treatment. Although the Knox-Keene Act (Act) currently requires health plans and dental plans to provide disclosure documents regarding benefits, exclusions and limitations of coverage, those documents are often lengthy and not as consumer friendly.

The SDBC will allow a consumer the ability to compare available dental coverage across carriers at a glance. SB 1008 accomplishes the legislature's goal by establishing a transparency requirement to assist consumers in understanding the services covered by a dental plan and provides consumers with the ability to easily compare dental benefits, limitations, and exclusions among the various dental carriers. In implementing a template SDBC, the Department is attempting to achieve the legislative goals of SB 1008 by providing clarity and transparency of dental benefits for consumers.

Pursuant to SB 1008, the uniform dental benefits matrix shall include: (1) the annual overall plan deductible; (2) the annual benefit limit; (3) coverage for the following categories: preventative and diagnostic services, basic services, major services, orthodontia services; (4) dental plan reimbursement levels and estimated enrollee cost-share for services; (5) waiting periods; and (6) examples illustrating coverage and estimated enrollee costs of commonly used benefits including, at least one service from each of the following categories: preventative and diagnostic, basic services, and major services.

The SDBC is a consumer-facing document and consists of six sections: (1) General Information, (2) Deductibles, (3) Maximums, (4) Waiting Periods, (5) What you Will Pay and (6) Coverage Examples. With regard to the "What You Will Pay" section, the SDBC requires the plan provide the cost for each service, and identifies the extent of coverage, e.g., the percentage or dollar amount that is the enrollee's responsibility, and all benefit limitations and exclusions.

This proposed regulation sets forth and clarifies the requirements of Health and Safety Code section 1363.04 and implements the goals of SB 1008 by providing a comprehensive and easily understandable SDBC for consumers. This proposed regulation ensures uniform implementation of the SDBC by health plans and dental plans

[5] Senate Bill (SB) 1008 (Skinner, Stats. 2018, ch. 933, § 2).
[6] *Id.*

and provides a greater understanding of dental coverage for consumers and enrollees.

Regulation Text

Subdivision (a)(1) of proposed title 28, CCR section 1300.63.4 (hereinafter "proposed regulation"), addresses the applicability of the proposed regulation to health plans and dental plans. Currently, the Department licenses health care service plans and specialized health care service plans. Health care service plans and specialized health care service plans are defined at Health and Safety Code section 1345(f) and (o). Subdivision (a)(1) is necessary to clarify the proposed regulation applies to both full-service health care service plans and specialized health care services plans offering a contract for dental services. Without this subdivision, it would be unclear whether the proposed regulation applies only to specialized health care service plans since dental plans are considered specialized health care service plans. Several full-service health care service plans currently offer dental services as separate benefits.[7] This provision clarifies that full-service health care service plans that offer a separate contract for dental services are required to abide by the proposed regulation. Specialized health care service plans offering dental coverage must also abide by the law.

The Department proposes to amend Subdivision (a)(1) of the emergency text to provide the specific date of compliance for health plans and dental plans. The Department added the specific date of compliance to the text, in accordance with Health and Safety Code section 1363.04(a), to clarify that health plan and dental plan contracts must provide the SDBC to consumers for contracts that are issued, sold, renewed, or offered on or after January 1, 2022. The addition of the compliance date is necessary to clarify for health plans and dental plans the contracts for which SDBCs will need to be provided to consumers or groups.

Subdivision (a)(2) provides clarity regarding the applicability of the proposed regulation to health care service contracts. The purpose of this provision is to clarify that if a health care service plan offers dental benefits as part of a contract for medical, surgical, and hospital services, it would not need to abide by the proposed regulation. The Department determined that in instances where the contract is mainly for medical, surgical, and hospital services, requiring plans to abide by the new proposed regulation would lead to enrollee confusion because the dental benefits provided within those contracts are very limited in scope. Therefore, when dental benefits are embedded or provided within the medical, surgical, and hospital contract, a health care service plan would not need to comply with the newly proposed regulation.

Subdivision (b)(1) defines "Group Contractholder." This provision provides for a consistent and uniform definition based on current Department regulations at title 28, CCR section 1300.65(a)(11). The authorizing statute requires the health plan or dental plan to

[7] Several health plans offer dental service contracts even though most of the contracts they offer are medical, surgical, and hospital services for medical conditions. This provision makes it clear that these full-service plans would still be required to abide by the proposed regulation because they also offer dental care coverage.

provide the SDBC to two parties: individuals and groups (employers). Group contractholders who are the employers contracting with the health plan or dental plan are also required to provide the SDBC to their employees or subscribers (the person who is responsible for payment to a plan or whose employment or other status, except for family dependency, is the basis for eligibility for membership in the plan). It is necessary to differentiate between the obligations health plans and dental plans have to groups (employers) and the obligations group contractholders have to their subscribers. By providing the same definition as used previously in the Knox-Keene Act, this subdivision also eliminates any ambiguity and inconsistent application of this term by the industry. The emergency regulation text contained a typographical error and referenced title 28, CCR section 1300.65(a)(6). Therefore, the Department proposes to revise the emergency regulation text to cite to the proper subdivision.

Subdivision (b)(2) defines "Plan." This provision is needed for clarity to ensure health plans or dental plans understand the usage of the general term "Plan." The reference is to both health care service plans and dental plans subject to the regulation as described in proposed subdivision (a)(1) and (a)(2).

Subdivision (b)(3) defines "Plan Year." This definition is necessary to clarify that when the proposed text refers to "Plan Year" the reference is to the time period covered by the health plan or dental plan contract. Coverage periods can be either calendar years or time periods negotiated by the plans and employer groups. Additionally, this subdivision ensures consistent use and understanding of this term by plans, consumers, and enrollees.

Subdivision (c) sets out the filing requirements for the SDBC. The Department proposes to amend the title of subdivision (c) by adding the word "Coverage," which was inadvertently omitted. Subdivision (c)(1) incorporates by reference the SDBC and incorporates by reference the accompanying Instruction Guide for use by the health plan or dental plan. The authorizing statute required the Department to create a SDBC to be used uniformly by plans. The goals of the SDBC are to provide a template for plans to use to ensure consumers and enrollees can compare dental coverage across the different plans offering coverage. The Instruction Guide provides detailed instructions to assist plans in filling out the SDBC to promote uniformity. To avoid any confusion on what precise information is required for the SDBC, the Department created detailed instructions explaining each required field.

Comprehensive instructions will ensure the SDBC is filled out properly by the health plan or dental plan and will benefit consumers and enrollees by enabling them to clearly understand coverage and compare the offered dental benefits. The Department is proposing to amend the regulation text to delete the dates on the SDBC and Instruction Guide and insert a direction to OAL to insert the date.

The Department has revised portions of the Instruction Guide and SDBC as they were incorporated by the emergency regulations. The changes are described below in the specific areas where they were made.

Subdivision (c)(2) clarifies for the health plan or dental plan that it may only reflect Department-approved dental benefits in the SDBC. Health and Safety Code sections 1351 and 1352 require a health plan or dental plan file the dental products it proposes to sell in the marketplace with the Department for the Department's review and approval. These consumer protection laws ensure the Department can verify and review whether the proposed dental products meet the requirements of the law. This subdivision is necessary to clarify a health plan or dental plan may not utilize the SDBC to reflect a dental benefit product not approved by the Department.

Subdivision (c)(3) explains filing requirements for the SDBC. In order to determine initial compliance with the requirements of SB 1008, the Department is requiring health plans and dental plans to file an electronic affirmation with the Department stating whether it is in compliance with the requirements of SB 1008 for those dental products currently approved for sale in the marketplace. The Department determined the administrative burden of requiring the submission of every SDBC for every dental product currently in existence would result in an increased workload for both the Department and the plan. Requiring an affirmation lessens the administrative burden for the Department and the health plan or dental plan.

The Department proposes to revise the regulation text to specify the date by which health plans and dental plans must submit affirmations for compliance to the Department by May 1, 2022, which is more than 15 months from the effective date of the emergency regulation. Specifying the date is necessary to provide clarity for health plans and dental plans.

Subdivision (c)(4) explains filing requirements for the SDBC. Entities seeking licensure by the Department to offer benefits must abide by the filing requirements described in Health and Safety Code section 1351. The plan's initial licensure filing must include disclosure documents describing the benefits the entity intends to offer to consumers. This provision is necessary to clarify that any entity seeking licensure with the Department must file a SDBC for the dental products it intends to offer for the Department's review.

Subdivision (c)(5)(A)-(C) explains filing requirements after initial licensure. Health and Safety Code section 1352 requires a plan to submit certain proposed changes to information initially filed for the Department's review at licensure. This provision describes instances or circumstances requiring submission of the SDBC. Subdivision (c)(5)(A) explains that if a plan is proposing a new dental product, it must submit the SDBC for the Department's review. Subdivision (c)(5)(B) explains that if the plan is proposing an amendment to a previously approved dental product, it must also submit the accompanying SDBC for the proposed amended dental product. Subdivision (c)(5)(C) explains that if the plan is proposing a change to a SDBC for which it affirmed compliance as part of the Department's initial compliance efforts described in subdivision (c)(3), it would need to submit the SDBC for the Department's review. These provisions are necessary to clarify the instances when plans are required to submit the SDBC for the Department's review.

Subdivision (d)(1)(A) implements Health and Safety Code section 1363.04(b) requiring a

health plan or dental plan provide the SDBC to consumers or enrollees in the individual market. This subdivision is necessary to clarify the timeframe of when a plan is to provide the SDBC to the individual who is either a consumer shopping for coverage or enrolled in coverage.

Subdivision (d)(1)(A)1. implements Health and Safety Code section 1363.04(b) explaining that when a plan presents a dental product for examination or sale to an interested consumer or prospective enrollee, it must also provide the individual with a SDBC. This implements the intent of the legislature in drafting SB 1008 because it provides the potential enrollee with a snapshot of what dental benefits are being offered and what the individual will have to pay for the offered benefits. It also allows the potential enrollee to compare dental benefits from other plans offering dental coverage who are also required to provide a SDBC.

Subdivision (d)(1)(A)2. requires a plan provide a SDBC to consumers who request the document within 7 days of the request. The Department is adopting the mandate in the federal SBC requirements that the SBC be given upon request within 7 days of the request.[8] This is necessary to clarify to the plan the timeframe in which it is to provide the SDBC to a consumer who requests the SDBC.

Subdivision (d)(1)(B)1. requires a plan to provide a consumer with a SDBC within 7 days of receiving an application for coverage along with any other disclosure information the entity is required to provide by existing law. This provision clarifies the timeframe in which the plan is to provide the SDBC to a consumer who applies for coverage with the entity.

Subdivision (d)(1)(B)2. explains that if a plan provided a SDBC during the shopping period and before the consumer's application was received, it does not have to provide the consumer with another SDBC so long as there are no changes to the SDBC provided during the shopping period. This is necessary to clarify the plan does not need to provide duplicate SDBCs if one was already provided to the consumer. If there are changes to the SDBC, the revised SDBC must be provided within the 7-day timeframe and no later than the first day of coverage to allow the consumer time to review the SDBC before coverage begins. This is vital in providing the consumer with full disclosure of the benefits provided and to alleviate any confusion before coverage begins.

Subdivision (d)(1)(C) addresses the circumstance of when benefits or other information contained in the SDBC changes between the time the consumer applies for coverage and receives a SDBC, and the first day of coverage. The plan must provide the SDBC to the consumer before the first day of coverage. This is vital in providing the consumer with full disclosure of the benefits provided and to alleviate any confusion before coverage begins.

Subdivision (d)(1)(D) addresses the circumstance of distribution of the SDBC when coverage is renewed and explains the timeframe of when a plan is to provide the SDBC when a consumer is reenrolling in coverage. It is necessary to address this circumstance since plans are currently required to provide other benefit disclosure materials when a

[8] 45 C.F.R. § 147.200(a)(1)(i)(D)

consumer is reenrolling in or renewing coverage. This subdivision clarifies that a plan must provide a SDBC along with the other disclosure materials it is required to provide. If automatic renewal occurs, the SDBC can be provided 30 days before coverage begins. This is vital in providing the consumer with full disclosure of the benefits provided and to alleviate any confusion before coverage begins.

Subdivision (d)(1)(E) describes and clarifies how the plan is required to deliver the SDBC to consumers or enrollees. Plans can choose to provide the SDBC in paper form, by electronic mail, or on their website. The Department is proposing a variation of the permissible delivery methods in the federal SBC requirements, which will provide plans flexibility. Further, the adoption of delivery methods is necessary to clarify the terms “make available” in the authorizing statute. The statute requires plans to “make available” the SDBC but it does not describe how the plan is to “make available” the SDBC to individuals, groups, and group contractors.

Subdivision (d)(1)(E)1. provides that a plan can deliver a SDBC in hard copy to the consumer or enrollee. This proposed subdivision is necessary to clarify that mailing the SDBC is an acceptable form of delivery.

Subdivision (d)(1)(E)2. provides that a plan can provide the SDBC electronically by email. This proposed subdivision is necessary to clarify that emailing the SDBC is an acceptable form of delivery. Also, the plan must advise the consumer that a paper copy is available free of charge and that the consumer can contact the health plan or dental plan with questions or concerns. This is necessary to ensure a consumer who is unable to print the SDBC, can still receive a copy from the health plan or dental plan as needed.

Subdivision (d)(1)(E)3. provides that a plan may meet its obligation to deliver the SDBC by posting the SDBC on its website. This proposed subdivision is necessary to clarify that posting of the SDBC on the plan’s website is an acceptable form of delivery. The Department is proposing to revise the emergency regulation text by making a nonsubstantive grammatical change to clarify the requirements for delivering the plan by posting on the website.

Subdivision (d)(1)(E)3.a. explains if the plan posts the SDBC on its website, the location must be prominent and easy to access for the consumer. This is necessary to ensure the consumer can quickly locate the SDBC for reference and comparison. This requirement is consistent with federal SBC requirements.

Subdivision (d)(1)(E)3.b. explains if the plan posts the SDBC on its website, the SDBC must allow for electronic retention such as saving and printing. This is necessary to ensure the consumer can keep a copy in their records and is able to have a hard copy if needed. This allows the consumer to reference the document and to compare the document with other dental benefits. This requirement is consistent with federal SBC requirements.

Subdivision (d)(1)(E)3.c. explains if the plan posts the SDBC on its website, the SDBC must be accessible to disabled individuals. This is necessary to prevent discrimination and

ensure all persons can access the SDBC. This requirement is consistent with federal SBC requirements.

Subdivision (d)(1)(E)3.d. explains if the health plan or dental plan posts the SDBC on its website, the plan must advise the consumer that a paper copy is available free of charge and that the consumer can contact the health plan or dental plan with questions or concerns. This is necessary to ensure a consumer who is unable to print the SDBC can still receive a copy from the health plan or dental plan as needed. The Department proposes to amend the emergency regulation text, which refers to individual contracts, to clarify that the plan is to advise the enrollee, not the group.

Subdivision (d)(2) implements Health and Safety Code section 1363.04(c) by describing and clarifying how the plan is required to deliver the SDBC to groups. The Department is proposing a variation of the permissible delivery methods in the federal SBC requirements, which will provide plans flexibility. The description of delivery methods is necessary to clarify the terms “make available” in the authorizing statute. The statute requires plans to “make available” the SDBC but it does not describe how the plan is to “make available” the SDBC to individuals, groups, and group contractholders. This subdivision describes the instances and timeframes in which the plan is to provide the SDBC to groups.

Subdivision (d)(2)(A) addresses when the plan is to deliver the SDBC to the group. This provision explains a plan is to provide the SDBC, along with other disclosure documents, at the time the group contracts for coverage. This is necessary to establish and clarify a time reference for delivery of the SDBC to groups.

Subdivision (d)(2)(B) addresses the circumstance of when benefits or other information contained in a SDBC change between the time the group signs the contract for coverage and receives a SDBC and the first day of coverage. The plan must provide the SDBC to the group before the first day of coverage. This is vital in providing the group with full disclosure of the benefits provided and to alleviate any confusion before coverage begins. The Department is proposing to revise the emergency regulation text by inserting the word “a.”

Subdivision (d)(2)(C) addresses the circumstance of distribution of the SDBC when coverage is renewed and explains the timeframe of when a health plan or dental plan is to provide the SDBC when a group is renewing or reenrolling in coverage. It is necessary to address this circumstance since plans are currently required to provide other benefit disclosure materials at this time. This subdivision clarifies that a plan would provide a SDBC along with the other disclosure material it is required to provide during this time. If automatic renewal occurs, the SDBC can be provided 30 days before coverage begins. This is vital in providing the group with full disclosure of the benefits provided and to alleviate any confusion before coverage begins.

Subdivision (d)(2)(D) describes and clarifies how the plan is required to deliver the SDBC to groups. Plans can choose to provide the SDBC in paper form, by electronic mail, or on their website. The Department adopted a variation of permissible delivery methods in the

federal SBC requirements to provide flexibility for plans. The provisions for delivery methods are necessary to clarify the terms “make available” in the authorizing statute. The statute requires plans to “make available” the SDBC but it does not describe how the plan is to “make available” the SDBC to individuals, groups, and group contractors.

Subdivision (d)(2)(D)1. provides that a plan can deliver a SDBC in hard copy to the group. This proposed subdivision is necessary to clarify that mailing the SDBC is an acceptable form of delivery.

Subdivision (d)(2)(D)2. provides that a plan can provide the SDBC electronically by email. This proposed subdivision is necessary to clarify that emailing the SDBC is an acceptable form of delivery. Also, the plan must advise the group that a paper copy is available free of charge and that the group can contact the health plan or dental plan with questions or concerns. This is necessary to ensure a consumer who is unable to print the SDBC can still receive a copy from the health plan or dental plan as needed.

Subdivision (d)(2)(D)3. provides that a plan can post the SDBC on its website. This proposed subdivision is necessary to clarify that posting of the SDBC on the plan’s website is an acceptable form of delivery. The Department is proposing to revise the emergency regulation text by making a nonsubstantive grammatical change to clarify the requirements for delivering the plan by posting on the website.

Subdivision (d)(2)(D)3.a. explains if the plan posts the SDBC on its website, the location must be prominent and easy to access for the group to access. This is necessary to ensure the group can quickly locate the SDBC for reference and comparison. This requirement is consistent with federal SBC requirements.

Subdivision (d)(2)(D)3.b. explains if the plan posts the SDBC on its website, the SDBC must allow for electronic retention such as saving and printing. This is necessary to ensure the group can keep a copy in their records and is able to have a hard copy if needed. This allows the group to reference the document and to compare the document with other dental benefits. This requirement is consistent with federal SBC requirements.

Subdivision (d)(2)(D)3.c. explains if the plan posts the SDBC on its website, the SDBC must be accessible to disabled individuals. This is necessary to prevent discrimination and ensure all persons can access the SDBC. This requirement is consistent with federal SBC requirements. The Department proposes to amend the emergency regulation text to rephrase the reference to federal and state law for consistency with subdivision (c)(1)(E)(3)(c).

Subdivision (d)(2)(D)3.d. explains if the health plan or dental plan posts the SDBC on its website, the website must advise the group that a paper copy is available free of charge and the group can contact the health plan or dental plan with questions or concerns. This is necessary to ensure a group who is unable to print the SDBC can still receive a copy from the health plan or dental plan as needed.

Subdivision (d)(3)(A) implements Health and Safety Code section 1363.04(d) requiring

group contractholders (employers) to provide the SDBC to subscribers and other eligible persons by clarifying what the group contractholder must provide at the time it offers coverage. This subdivision clarifies that prior to enrollment the group contractholder must provide the SDBC along with other benefit disclosure material. This is necessary to clarify the timeframe of SDBC delivery during the pre-enrollment period and to ensure consumers can compare the different dental benefits offered by the group contractholder.

Subdivision (d)(3)(B) implements Health and Safety Code section 1363.04(d) by clarifying that the group contractholder must deliver the SDBC to the subscriber when it delivers other application materials. This is required to ensure those persons receive the applicable SDBC along with the corresponding disclosure materials. This ensures full and fair disclosure to the employee prior to choosing a dental benefit plan offered by the employer and allows the enrollee the opportunity to review what dental benefits are being offered before coverage begins.

Subdivision (d)(3)(B)1. implements Health and Safety Code section 1363.04(d) by clarifying the time period for delivering the SDBC to applicants for coverage. The Department is proposing to mandate that the SDBC be provided within 7 days of receipt of the application, as provided for in federal SBC requirements. This is vital to provide the consumer with full disclosure of the benefits provided and to alleviate any confusion before coverage begins.

Subdivision (d)(3)(B)2. implements Health and Safety Code section 1363.04(d) by clarifying that if a group contractholder provided a SDBC to an eligible person prior to the subscriber applying it does not have to provide a duplicate SDBC unless there has been a change in the SDBC. If there has been a change, the employer shall provide the current SDBC to the employee within 7 days after receipt of the application but no later than the first day of coverage. This ensures the enrollee has the most current information regarding dental benefits before coverage begins and eliminates the need for the employer to duplicate efforts unless needed.

Subdivision (d)(3)(C) clarifies that if there are any changes in the SDBC between the date of application and the first day of coverage, the employer must provide the employee with a revised SDBC no later than the first day of coverage. This ensures the enrollee has the most current information regarding dental benefits before coverage begins and eliminates the need for the employer to duplicate efforts unless needed.

Subdivision (d)(3)(D) addresses the circumstance of distribution of the SDBC when coverage is renewed and explains the timeframe of when a group contractholder is to provide the SDBC when reenrolling employees for coverage. It is necessary to address this circumstance because employer groups are currently required to provide other benefit disclosure material at this time. This subdivision clarifies that a group contractholder must provide a SDBC no later than the date on which it distributes other disclosure materials. If automatic renewal occurs, the SDBC must be provided no later than 30 days before coverage begins. This is vital in providing the consumer with full disclosure of the benefits provided and to alleviate any confusion before coverage begins.

Subdivision (d)(3)(E) describes and clarifies how the group contractholder is required to deliver the SDBC to subscribers. The adoption of delivery methods is necessary to clarify the terms “make available” in the authorizing statute. The statute requires group contractholders to “make available” the SDBC but it does not describe how to “make available” the SDBC to subscribers.

Subdivision (d)(3)(E)1. explains the group contractholder can mail the SDBC to the individual’s mailing address. This is necessary to clarify the group contractholder may mail the SDBC.

Subdivision (d)(3)(E)2. provides that a group contractholder can provide the SDBC electronically by email. This proposed subdivision is necessary to clarify that emailing the SDBC is an acceptable form of delivery. The group contractholder must advise the subscriber that a paper copy is available free of charge and the plan can be contacted for a paper copy or with questions. This is necessary to ensure a subscriber who does not print the SDBC can still receive a copy from the plan.

Subdivision (d)(3)(E)3. provides that a group contractholder can direct a subscriber to the plan’s website for a copy of the SDBC, but only if the contractholder received the SDBC via the plan’s website. In that case, the group contractholder can refer the subscriber to the plan’s website for a copy of the SDBC. This will allow the enrollee easy access to the SDBC on the plan’s website. The Department modified the text adopted as an emergency by clarifying that this method of delivery is available only when a contractholder itself has received the SDBC from the plan’s website. This is necessary to ensure that the enrollee is directed to a website to access a copy of the SDBC only if the contractholder originally accessed the SDBC from a website.

Subdivision (e) implements Health and Safety Code section 1363.04(e) requiring health plan or dental plan and group contractholders to provide the SDBC during special enrollment periods of coverage described in existing law.[9] This provision is necessary to ensure an SDBC is distributed to the consumer along with other disclosure materials the entity is required to provide by existing law to allow the consumer to evaluate and compare dental benefits.

Subdivision (f) implements Health and Safety Code section 1363.04(e) requiring health plan or dental plan and employers provide the SDBC when requested by the enrollee. This provision is necessary to describe the timeframe in which the SDBC must be provided and the way the SDBC should be provided. This provision adopts the delivery and timeframe from other subdivisions in this proposed regulation for consistency and uniformity.

Subdivision (g) explains the health plan or dental plan is responsible for assuring its contracting employer groups comply with the provisions of the proposed regulations. The Department regulates health plans and specialized plans.[10] The Department also

[9] “Special enrollment period” is defined at Health & Saf. Code § 1399.849.
[10] Health & Saf. Code § 1341

regulates the health and dental products offered by employers to employees. This provision is necessary to ensure health plans or dental plans understand they are obligated to ensure the employers they contract with are distributing the SDBC to consumers enrolled in insurance plans.

Subdivision (h) is necessary to explain and clarify that if a health plan or dental plan subcontracts or delegates responsibilities described in this proposed regulation, it remains responsible for ensuring its subcontractor or delegate complies with the requirements of the proposed regulation.

Subdivision (i) is required to clarify translation requirements for health plans and dental plans. Health and Safety Code section 1367.04 and title 28, CCR section 1300.67.04, require health plans or dental plans to translate certain enumerated documents for enrollees requiring such services. The SDBC is an important document that summarizes dental care coverage for consumers. This provision clarifies health plans or dental plans are required to ensure they are abiding by current law in translating the SDBC for consumers. The Department proposes to amend the text adopted as an emergency regulation by inserting "Health and Safety Code," which had been inadvertently omitted from the text.

Subdivision (j) is necessary to explain and clarify that enforcement provisions available to the Department apply to non-compliance with the provisions of the proposed text.

Instruction Guide for Summary of Dental Benefits and Coverage Disclosure Matrix

The following information describes the purpose and necessity of each provision proposed by the Instruction Guide. The Department has revised portions of the Instruction Guide that were adopted in the emergency rulemaking. The Department is proposing to delete the date on the Instruction Guide and insert a direction to OAL to insert the date. The remaining changes are described below in the specific areas where they were made.

Page 1: Instructions and Formatting for the Entire Summary of Dental Benefits and Coverage Disclosure Matrix.

A. The Department is requiring the SDBC to be a stand-alone document. Health plans and dental plans are required to provide enrollees with numerous disclosure documents regarding coverage, exclusions to coverage, and limitations to coverage. The Evidence of Coverage document serves as the contract between the plan and the enrollee. The Evidence of Coverage is lengthy and describes all the different benefits, limitation, and exclusion provisions covered by the medical or dental service contract. The Department finds it necessary to ensure the SDBC serves as a summary and stand-alone document that enrollees can easily refer to as a comparison of benefits. This provision is necessary to ensure plans are not combining the SDBC with other disclosure documents that may be lengthy which can lead to enrollee confusion and hinder the goals of SB 1008.

B. The Department is not allowing plans to edit the SDBC unless otherwise specified in the Instructions or SDBC itself. This is necessary to ensure all plans are consistent and

uniform in how they display information in the SDBC. This instruction is necessary to accomplish the goal of providing a uniform document to enrollees and consumers.

C. This instruction directs the health plan or dental plan to use Arial 12-point font for consistency and readability across health plans. The federal SBC requirements mandate plans use 12-point font and encourages plans to use 12-point Arial Narrow font. This provision is necessary for uniformity across plan documents.

D. This Item clarifies and explains the plan is to insert information into the bracketed, red font, and remove the brackets and red font prior to distribution to enrollees. This is necessary for uniformity across plans and to avoid enrollee confusion.

Page 1, Part I. General Information

A and B. This instruction explains to health plans and dental plans the identifying information they are required to enter as follows: “Plan Name,” “Type of Product Line,” and “Name of Product.” Plan name is necessary to identify which health plan or dental plan is providing the benefits contained in the SDBC. “Type of Product Line” explains whether the dental benefits at issue are offered as a Health Maintenance Organization (HMO) or Preferred Provider Organization (PPO). “Name of Product” is necessary to identify the dental benefit product that is being described in the SDBC. Each dental benefit product has a set of benefits, limitations, and exclusion provisions. In this field, the plan is to describe the identifier for the dental benefit product described in the SDBC. By identifying the “Name of Product,” enrollees will be able to attribute a name to the dental benefit product offered by the plan and can identify the enrollee’s membership in a particular product line. This will facilitate the enrollee in comparing dental products across plans. Moreover, enrollees will be able to identify what product they are enrolled in once a plan is chosen. This will allow the enrollee to receive accurate information for their benefits when speaking with dental providers or the plans.

C. Health plans and dental plans are required to enter the “Effective Date” of the offered dental coverage. As explained above in the “Plan Year” definition, dental benefits are offered during a specific period of time. For an enrollee or consumer, it is important to know when dental coverage begins and ends. An enrollee or consumer will not be able to receive dental benefits before coverage begins and will not be able to receive coverage once dental coverage ends. Therefore, it is necessary for the enrollee or consumer to know when the benefits described in the SDBC begin and end. Because some employer groups automatically renew coverage, the Department allowed for flexibility by allowing plans to insert the beginning date of coverage to account for variability in group contracting.

D. Health plans and dental plans are required to insert the plan’s customer service phone number for enrollees to reach the plan with any questions. It is necessary for the enrollee to have easy access to plan contact information if there are any questions regarding dental coverage.

Page 1, Part II. Deductibles

A. This instruction implements Health and Safety Code section 1363.04(a)(1), requiring a SDBC to note any annual overall plan deductible. Accordingly, this provision ensures there is a consistent use and understanding of what deductible amount will need to be paid by the enrollee before the health plan or dental plan will pay for dental benefits. This provision is vital to a consumer or enrollee's understanding of the applicable dental benefits offered and ensures consumers are clearly informed of offered benefits. Further, the consumer or enrollee will be able to compare deductibles across plans to evaluate what dental plan works best for their economic situation.

B: The Department created template language to assist the health plan and dental plan in describing the services for which the deductible applies. Typically, there are dental services that are not subject to the deductible, such as preventative dental care services. If a particular service within the dental benefit package is not subject to the deductible, then the health plan or dental plan would so state in this section of the SDBC. This is necessary for full disclosure to the consumer or enrollee.

The Department is proposing to amend the Instruction Guide by adding an instruction regarding any annual orthodontia deductibles. This is necessary to allow the health plan or dental plan to list any annual orthodontia applicable to the product.

Page 1, Part III: Annual Maximum and Lifetime Maximum for Orthodontia

A. This instruction implements Health and Safety Code section 1363.04(a)(2), requiring a SDBC to list or provide the annual benefit limit or maximum amount the plan will pay for dental benefits described in the SDBC for both in-network services and out-of-network services, if out-of-network services are a benefit. Further, the Department included a provision for lifetime maximum for Orthodontia, since Orthodontic services almost always include a maximum dollar amount the plan will pay during an enrollee's lifetime. It is necessary to disclose this information to the enrollee to allow the enrollee to evaluate and compare the benefits offered between dental plans.

B. This instruction is necessary to explain that if there is an out-of-network benefit, the cost-sharing, meaning the amount the enrollee will pay, will be higher and the enrollee should contact the plan for further guidance. The Department understands that it is difficult to determine enrollee costs when an enrollee obtains dental services out-of-network, that is, from a dentist who has no contract with the dental plan. Therefore, the SDBC directs the enrollee to contact the plan.

The Department proposes to amend the Instructions that were adopted as an emergency. The Department is proposing to add a fourth option for plans to select in reporting information for maximums for out-of-network services. The added option, which appears first in the list, allows the plan to enter a dollar amount. This is necessary to account for the instances when the applicable product explained in the SDBC has an out-of-network dollar amount cap. Providing the plan with four choices of applicable language will enable the plan to provide the most accurate information available for the enrollee's benefit.

Page 1, Part IV: Waiting Periods

A. This instruction implements Health and Safety Code section 1363.04(a)(5), requiring a SDBC to state whether the health plan or dental plan requires a waiting period to receive the dental benefits described in the SDBC. This instruction identifies the information the health plan must include when explaining whether a waiting period applies. It is necessary to disclose this information to the enrollee to allow the enrollee to evaluate and compare the benefits offered between dental plans.

Page 1 and 2, Part V: What You Will Pay

A. This instruction implements Health and Safety Code section 1363.04(a)(3), requiring a SDBC to list and explain covered dental services with the corresponding copayments or coinsurance, for in-network or out-of-network care, for the following categories of services: Preventative and Diagnostic, Basic, Major, Orthodontia. Within these categories are specific types of dental services or procedures. Dental plans are required to file various documents with the Department, which, among other things, identify dental procedures. The Department chose the following services to be illustrated in the SDBC: oral exam, Bitewing X-Ray, cleaning, filling, simple extraction, root canal, scaling and root planing, ceramic crown, removable partial denture, and 3-unit bridge. In order to make the SDBC meaningful for the consumer, it was necessary for the Department to choose common dental services for all plans to display uniformly in the SDBC to allow the consumer to compare out-of-pocket costs across plans for the same common services.

The Department is amending three items on the list of services: revising the description of what had been “Simple Extraction” and “3 Unit Bridge” in both the Instructions and the SDBC, and adding explanatory material in the Instructions regarding “Removable Partial Denture.” This is necessary to provide a more meaningful and clearer SDBC to consumers based on accurate dental services for each category of services.

B. This instruction implements Health and Safety Code section 1363.04(a)(3), requiring the SDBC to list coverage for the categories of services described above. This column captures what category of service the more specific dental service falls under.

C. This instruction explains two columns: in-network and out-of-network care. The instruction is for the health plan or dental plan to describe what the cost-share will be for the service, either in the form of a percentage for PPO products or a dollar amount for HMO products, if the service is received in-network versus out-of-network. This instruction provides the plans with a means of providing the information in a consistent and clear way for the enrollee to understand what dental benefits are offered and what potential out-of-pocket costs are.

D. This instruction explains that if a dental product does not have an out-of-network benefit, the health plan or dental plan shall state “not applicable” in the designated out-of-network column. This is necessary for clarity and transparency of dental benefits for consumers and enrollees.

E. This instruction implements Health and Safety Code section 1363.04(a). This instruction is necessary to direct the health plan or dental plan to explain whether there are any benefit limitations or exclusions for the services received. Limitations and exclusions include, for example, limits on the frequency of services, any waiting periods to begin receiving services, any differences in enrollee cost-sharing for services provided by a specialist dentist, and services that are excluded from coverage if received by a particular type of dentist (general or specialized). Since the SDBC is only a summary of benefits, the Department is requiring a cross-reference to the larger disclosure document that explains the limitation or exclusion in detail. This is vital and necessary for full disclosure to the consumer or enrollee of the limitations for benefits provided, and to allow the enrollee the opportunity to further research the limitation or exclusion.

Page 2, Part VI: Coverage Examples

Overview: This section implements Health and Safety Code section 1363.04(a)(6) requiring a SDBC to contain examples to illustrate coverage and estimated enrollee costs of commonly used benefits. The examples must include specific dental services from the service categories described above. The federal SBC also includes coverage examples. Coverage examples allow consumers to compare costs.

The Department proposes to amend the SDBC adopted as part of the emergency regulation by revising the coverage examples. The Department utilized data from the Medi-Cal Dental Program provided by the California Department of Health Care Services (DHCS) to approximate the total in-network cost, and coverage data from the largest commercial dental provider in California to approximate in-network costs for the coverage example.

Updates to Part VI: Coverage Examples
The Total Cost of Care in Part VI of the SDBC is proposed to be revised as indicated below:

1. New patient exam, x-rays (FMX) and cleaning
    a. In-network: $400
    b. Out-of-network: $550
2. Resin-based composite – one surface, posterior
    a. In-network: $150
    b. Out-of-network: $200
3. Crown – porcelain/ceramic substrate
    a. In-network: $1,300
    b. Out-of-network: $1,750

In developing the coverage examples for the SDBC, the Department utilized data from the California Medi-Cal Dental Program provided by DHCS. To approximate the in-network total cost of care for each service in the coverage examples section, the Department started by obtaining the maximum allowance for each service, as identified in the California Medi-Cal Dental Program Provider Handbook.[11] DHCS typically reimburses less

[11] https://www.dental.dhcs.ca.gov/Dental_Providers/Medi-Cal_Dental/Provider_Handbook/

than commercial dental plans in California. According to DHCS analysis, their average payment rate for the 25 most utilized services was 26.2 percent of the "Pacific Division" average (which includes California) during State Fiscal Year 2017-2018.[12] Therefore, to obtain the approximate in-network total cost of care that is more consistent with California commercial costs, the Department increased the cost of each service by 381.7% to comply with the Pacific Division average.

In order to approximate the out-of-network total cost of care for each service, the Department utilized an example from Delta Dental's website to estimate how much out-of-network costs may differ from the in-network cost. In reviewing Delta Dental's example, the out-of-network cost (identified as the dentist's fee) was 35 percent higher than the in-network cost. Therefore, the Department took the in-network costs and increased them by 35 percent to obtain the approximate out-of-network cost for each service.

This section is not a cost estimator, and instead is to be used to compare dental products. The Department therefore rounded the numbers to the nearest 50 to make the examples easier to understand. This is necessary to ensure the SDBC is consist for enrollee comparison across plans. This is also consistent with the instructions to health plans for completing the federal SBC requirements, which state: "each plan … must leave the Total Example Cost as is." (Summary of Benefits Instruction Guide for Group Coverage, p. 18.)[13]

The chart below shows the DHCS maximum allowance for each service, plus the adjustment for the approximate commercial cost for in-network and the adjustment for out-of-network.

Services Currently in Matrix	**DHCS Max Allowance**	**CA Avg. Max Allowance (In Network)**	**Out of Network**
D2740 Crown – porcelain/ceramic substrate	$340	$1297.71	$1751.90
D2391 Resin-based composite – one surface, posterior	$39	$148.85	$200.94
D1110 Prophylaxis – adult	$40	$152.67	$206.10
D0150 Comprehensive oral evaluation – new or established patient	$25	$95.41	$128.80

[12] The maximum allowable Medi-Cal Dental rate is considered here to be the rate at which providers bill payors and are reimbursed. https://www.dhcs.ca.gov/services/Documents/MDSD/Dental%20Data%20Reporting/2019-Dental-Rate-Review.pdf

[13] See also Simple Fracture Guide (cited in the Documents Relied Upon section of this document), which states on page 1: "Instructions to Plans and Issuers: Do not modify this table. The numbers shown here come from the Scenario table." The total simple fracture care cost given there is $2,800.

D0210 Intraoral - complete series of radiographic images	$40	$152.67	$206.10
D1110, D0150, D0210 - New patient exam, x-rays (FMX) and cleaning	$105	$400.75	$541

A. This instruction implements Health and Safety Code section 1363.04 (a)(6), requiring the SDBC include "examples to illustrate coverage and estimated enrollee costs of commonly used benefits." The plans are to include cost of care based on the Department's calculation above. This is necessary for consistency across health plans or dental plans.

B. This instruction implements Health and Safety Code section 1363.04(a)(6), requiring the SDBC illustrate coverage and estimated enrollee costs for the applicable dental benefit product described in the SDBC. This instruction is necessary to explain to the health plan or dental plan that it must provide the deductible, annual maximum, copayment or coinsurance, and cost information for the dental product described in the SDBC. These items are necessary to provide the enrollee or consumer with an example of potential costs for services and how different costs or limitations effect enrollee cost-sharing for the dental benefits at issue.

C. This instruction explains that the health plan or dental plan is to differentiate between in-network costs and out-of-network costs and instructs the plan how to report services that are not covered. This instruction is necessary to ensure that the SDBC illustrates to the enrollee the potential cost differential of seeking services out-of-network if that benefit is provided.

D. This instruction describes how to complete the SDBC if there is no applicable deductible. This is necessary to ensure the enrollee has a fair estimate and disclosure of the dental product the enrollee is purchasing.

E. This instruction explains how the health plan or dental plan is required to calculate the hypothetical cost share the enrollee would be responsible for based on the "Total Cost of Care" example provided. This is necessary to provide an example of what the enrollee's cost share would be because final costs would be dependent upon the applicable deductible, annual maximum amount, and the applicable cost-sharing amount for the provided service based on the benefits of the dental product illustrated in the SDBC.

F. The final instruction in this part directs the plan to include in the referenced row the information it listed in Part V., E., i-iv. This is necessary to explain to the plan that it must list benefit, limitations, and exclusions in this row.

Summary of Dental Benefits and Coverage Disclosure Matrix (SDBC)

The following information describes the purpose and necessity of each provision

proposed by the SDBC. The Department has revised portions of the SDBC that was adopted in the emergency rulemaking. Those changes to the SDBC as incorporated in the emergency regulation are described below in the specific areas where they were made. Enrollees will receive neither the regulation text nor the Instruction Guide, but only the SDBC. Therefore, as noted below, the Department has chosen to include some items, for example, some definitions, in the SDBC, rather than in the Instruction Guide or regulation text.

Header and Footer on First Page
The Department proposes to remove the Department logo and to also remove the identifying information from the header and replace it with a footnote with the identifying information. This amendment recognizes that the plans prepare and deliver the SDBC to the consumers.

Page 1, Part 1, General Information: In developing the SDBC, the Department was guided by the format and appearance of the federal medical SBC and is adopting certain disclosure provisions from the federal SBC. For example, the Department is requiring a disclosure paragraph that explains what the SDBC does, and clarifies that it is only a summary of benefits and is not a guarantee of expenses or payment. This disclosure paragraph is necessary to provide full and fair disclosure to the consumer or enrollee.[14] Further, the disclosure ensures the consumer or enrollee has a clear understanding of the purposes of the SDBC.

As described in the necessity and purpose rationale related to the Instruction Guide, the General Information in Part 1 is necessary to assist the enrollee in easily identifying what dental benefits are described in the SDBC, what health plan or dental plan is offering the benefits, and how to contact the health plan or dental plan with questions or concerns.

Page 1, Part II: Deductibles: This section implements Health and Safety Code section 1363.04(a)(1), requiring a SDBC to include any annual overall plan deductible. Accordingly, this provision ensures there is a consistent use and understanding of what deductible amount will need to be paid by the enrollee before the health plan or dental plan will pay for dental benefits. This provision is vital to an enrollee's understanding of the applicable dental benefits offered and ensures an enrollee is clearly informed about what the plan offers. Further, the enrollee will be able to compare deductibles across health plans to evaluate what dental plan works best for their economic situation.

This section of the SDBC defines "deductible." This definition provides for a consistent and uniform understanding and application of this term. The health plans and dental plans file documents with the Department in connection with their licenses that include definitions for the term "deductible." While there are slight variations in definitions among plan documents, the Department adopted a definition consistent with the substance of the definitions used by most plans. The Department is requiring the definition be placed in the applicable portion of the SDBC, rather than in the regulation text, for easy enrollee

[14] Health & Saf. Code § 1363(a) requires a plan to provide full and fair disclosure of benefits provided in written materials that are clear and organized.

reference. The definition of the term eliminates confusion by providing a consistent and uniform definition that is easily understandable by the plans and enrollees.

This section of the SDBC defines “In-network services.” This definition provides for a consistent and uniform understanding and application of this term. The health plan and dental plan license filings include definitions for the term “In-network services.” The Department adopted a definition that was consistent with the substance of the definitions used by most plans. The Department is including the definition itself in the applicable portion of the SDBC, rather than in the regulation text, for easy enrollee reference. The definition of the term eliminates confusion by providing a consistent and uniform definition that is easily understandable by the plans and enrollees.

This section of the SDBC defines “Out-of-network services.” This definition provides for a consistent and uniform understanding and application of this term. health plan and dental plan license filings contain definitions for the term “Out-of-network services.” The Department adopted a definition that was consistent with the substance of the definitions used by most plans. The Department is requiring the definition itself to be placed in the applicable portion of the SDBC, rather than in the regulation text, for easy enrollee reference. The definition of the term eliminates confusion by providing a consistent and uniform definition that is easily understandable by the plans and enrollees.

Page 2, Part III: Maximums Plan Will Pay

This section of the SDBC implements Health and Safety Code section 1363.04(a)(2), requiring a SDBC to list or provide the annual benefit limit the plan will pay for dental benefits described in the SDBC for both in-network services and out-of-network services, if out-of-network services are a benefit. Further, the SDBC includes a provision for lifetime maximum for Orthodontia as Orthodontic services almost always include a maximum dollar amount the health plan or dental plan will pay during an enrollee’s lifetime. The Department is proposing to amend the table to add a fourth option for plans to select in reporting information for maximum amounts for out-of-network services. The added option, which appears first in the list, allows the plan to enter a dollar amount. This is necessary to account for the instances when the applicable product explained in the SDBC has an out-of-network dollar amount cap. Providing the plan with four choices of applicable language will enable the plan to provide the most accurate information available for the enrollee’s benefit. This is necessary to account for the instances when the applicable product explained in the SDBC has an out-of-network dollar amount cap. It is necessary to disclose this information to the enrollee to allow the enrollee to evaluate and compare the benefits offered between dental plans.

This section of the SDBC defines “Annual maximum.” This definition provides for a consistent and uniform understanding and application of this term. Health plan and dental plan license filings provide definitions for the term “Annual maximum,” as they do for definitions in the Deductibles section of the SDBC. The Department adopted a definition that was consistent with the substance of the definitions used by most plans. The Department is requiring the definition to be included in the applicable portion of the SDBC, rather than in the regulation text, for easy enrollee reference. The definition of the term

eliminates confusion by providing a consistent and uniform definition that is easily understandable by the plans and enrollees. Further, the Department is proposing to amend the description of the annual maximum that appears below the table by adding a sentence to explain that certain services will not accrue to the annual maximum. This proposed change will further clarify the costs enrollees may incur.

This section of the SDBC defines “Lifetime maximum.” This definition provides for a consistent and uniform understanding and application of this term. Health plan and dental plan license filings include definitions for the term “Lifetime maximum.” The Department adopted a definition that was consistent with the substance of the definitions used by most plans. The Department decided to require the definition itself to be placed in the applicable portion of the SDBC, rather than in the regulation, for easy enrollee reference. The definition of the term eliminates confusion by providing a consistent and uniform definition that is easily understandable by the plans and enrollees.

Page 2, Part IV: Waiting Periods

This section implements Health and Safety Code section 1363.04(a)(5), requiring a SDBC to provide information regarding waiting periods. This section provides the information the health plan is to provide, namely a description of the any waiting period to receive dental services. It is necessary to disclose this information to the enrollee to allow the enrollee to evaluate and compare the benefits offered between dental plans.

This section of the SDBC defines “Waiting periods.” This definition provides for a consistent and uniform understanding and application of this term. As noted above with regard to proposed definitions in other sections of the SDBC, health plan and dental plan license filings contain definitions, including for the term “Waiting Periods.” The Department adopted a definition that was consistent with the substance of the definitions used by most plans. The Department is mandating the definition itself be placed in the applicable portion of the SDBC, rather than in the regulation text, for easy enrollee reference. The definition of the term eliminates confusion by providing a consistent and uniform definition that is easily understandable by the plans and enrollees.

Page 2 and 3, Part V: What You Will Pay

This section implements Health and Safety Code section 1363.04(a)(3), requiring a SDBC list and explain covered dental services with the corresponding copayments and coinsurance, for in-network or out-of-network care, for the following categories of services: Preventative and Diagnostic, Basic, Major, Orthodontia. Within these categories are specific types of dental services or procedures.

Common Dental Procedures Column

Dental plans are required to file various documents with the Department, which, among other things, identify dental procedures. The Department chose the following services to be illustrated in the SDBC: oral exam, Bitewing X-Ray, cleaning, filling, simple extraction, root canal, scaling and root planing, ceramic crown, removable partial denture, and 3-unit

bridge. In order to make the SDBC meaningful for the consumer, it was necessary for the Department to choose common dental services for all plans to display uniformly in the SDBC to allow the consumer to compare out-of-pocket costs across plans for the same common services.

The Department is proposing to amend the description of two items on the list of services in the SDBC: what had been “Simple Extraction” and “3 Unit Bridge.” The SDBC has been revised to change the following: simple extraction is revised to extraction, erupted tooth, or exposed root; and 3 Unit Bridge is revised to Extraction, Erupted Tooth with Bone Removal. (The explanation for a third service, removal of partial denture, was changed in the Instruction Guide.) This is necessary to provide a more meaningful and clearer SDBC to consumers based on accurate dental services for each category of services.

Category Column

This column implements Health and Safety Code section 1363.04(a)(3) requiring the SDBC reflect services in the three categories of: Preventative and Diagnostic, Basic, Major, and Orthodontia. This column requires the plan to insert the category of service the common dental procedure falls into. This is necessary for the plan to accurately represent dental services offered to consumers and enrollees.

In-network and Out-of-Network Columns

These columns are necessary to clarify the format for health plans and dental plans to describe the cost-share. The plans must show the cost share, either in the form of a percentage or a dollar amount for the service, and must state if it is received in-network versus out-of-network. This column provides the health plan or dental plan with a means of providing the information in a consistent and clear way for the enrollee to understand what dental benefits are offered and what out-of-pocket costs are for the particular service.

Benefit Limitations and Exclusions Column

This column implements Health and Safety Code section 1363.04(a), requiring an SDBC to list any limitations to dental services reflected in the SDBC. This column is necessary to direct the health plan or dental plan to explain whether there are any benefit limitations or exclusions for the services received. Limitations and exclusions include, for example, limits on the frequency of services, any waiting periods to begin receiving services, differences in cost-sharing if a service is provided by a specialist dentist, and any exclusion from coverage if the service is covered only if received by a particular type of dentist (general or specialized). Since the SDBC is only a summary of benefits, the Department is requiring a cross-reference to the larger disclosure document that explains the limitation or exclusion in detail. This is vital and necessary for full disclosure to the consumer or enrollee of the limitations for benefits provided, and to allow the enrollee the opportunity to further research the limitation or exclusion.

Page 3 and 4, Part VI: Coverage Examples

This section implements Health and Safety Code section 1363.04, subdivision (a)(6) requiring a SDBC to contain examples to illustrate coverage and estimated enrollee costs of commonly used benefits. As required by the SBC for medical products, the SDBC also requires that a health plan or dental plan provide coverage examples to allow for comparison. The examples must include specific dental services from the service categories described above. The Department proposes to amend the SDBC adopted as part of the emergency regulation by revising the coverage examples. The Department utilized data from the Medi-Cal Dental Program provided by the California Department of Health Care Services (DHCS) to approximate the total in-network cost, and coverage data from the largest commercial dental provider in California to approximate in-network costs for the coverage example.

Updates to Part VI: Coverage Examples
The Total Cost of Care in Part VI of the SDBC is proposed to be revised as indicated below:

1. New patient exam, x-rays (FMX) and cleaning
    a. In-network: $400
    b. Out-of-network: $550
2. Resin-based composite – one surface, posterior
    a. In-network: $150
    b. Out-of-network: $200
3. Crown – porcelain/ceramic substrate
    a. In-network: $1,300
    b. Out-of-network: $1,750

In developing the coverage examples for the SDBC, the Department utilized data from the California Medi-Cal Dental Program provided by the California Department of Health Care Services (DHCS). To approximate the in-network total cost of care for each service in the coverage examples section, the Department started by obtaining the maximum allowance for each service, as identified in the California Medi-Cal Dental Program Provider Handbook.[15] DHCS typically reimburses less than commercial dental plans in California. According to DHCS analysis, their average payment rate for the 25 most utilized services was 26.2 percent of the "Pacific Division" average (which includes California) during State Fiscal Year 2017-2018.[16] Therefore, to obtain the approximate in-network total cost of care that is more consistent with California commercial costs, the Department increased the cost of each service by 381.7% to comply with the Pacific Division average.

In order to approximate the out-of-network total cost of care for each service, the Department utilized an example from Delta Dental's website to estimate how much out-of-network costs may differ from the in-network cost. In reviewing Delta Dental's example,

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[15] https://www.dental.dhcs.ca.gov/Dental_Providers/Medi-Cal_Dental/Provider Handbook/
[16] The maximum allowable Medi-Cal Dental rate is considered here to be the rate at which providers bill and are reimbursed. https://www.dhcs.ca.gov/services/Documents/MDSD/Dental%20Data%20Reporting/2019-Dental-Rate-Review.pdf

the out-of-network cost (identified as the dentist's fee) was 35 percent higher than the in-network cost. Therefore, the Department took the in-network costs and increased them by 35 percent to obtain the approximate out-of-network cost for each service.

The SDBC is not a cost estimator, and instead is to be used to compare dental products. The Department therefore rounded the numbers to the nearest 50 to make the examples easier to understand. This is necessary to ensure the SDBC is consist for enrollee comparison across plans. This is also consistent with the instructions to health plans for completing the federal SBC requirements, which state: "each plan … must leave the Total Example Cost as is." (Summary of Benefits Instruction Guide for Group Coverage, p. 18.)[17]

The chart below shows the DHCS maximum allowance for each service, plus the adjustment for the approximate commercial cost for in-network and the adjustment for out-of-network.

Services Currently in Matrix	**DHCS Max Allowance**	**CA Avg. Max Allowance (In Network)**	**Out of Network**
D2740 Crown – porcelain/ceramic substrate	$340	$1297.71	$1751.90
D2391 Resin-based composite – one surface, posterior	$39	$148.85	$200.94
D1110 Prophylaxis – adult	$40	$152.67	$206.10
D0150 Comprehensive oral evaluation – new or established patient	$25	$95.41	$128.80
D0210 Intraoral - complete series of radiographic images	$40	$152.67	$206.10
D1110, D0150, D0210 - New patient exam, x-rays (FMX) and cleaning	$105	$400.75	$541

Deductible, Annual Maximum, and Patient Costs Columns

These columns implement Health and Safety Code section 1363.04(a)(6), requiring the SDBC illustrate coverage and estimated enrollee costs for the applicable dental benefit design described in the SDBC. These columns are necessary to illustrate to the enrollee the deductible, annual maximum, copayment or coinsurance, and cost information for the

[17] See also Simple Fracture Guide (cited in the Documents Relied Upon section of this document), which states on page 1: "Instructions to Plans and Issuers: Do not modify this table. The numbers shown here come from the Scenario table." The total simple fracture care cost given there is $2,800.

dental product described in the SDBC. These items are necessary to provide the enrollee with an example of potential costs for services and how different costs or limitations can affect enrollee cost-sharing for the dental benefits at issue. The Department is proposing to amend the SDBC to add an option for the plan to enter a dollar amount if the dental product has an applicable dollar amount cap for the Annual Maximum for out-of-network services.

In-Network and Out-of-Network Fields

These fields allow the health plan or dental plan to differentiate between in-network costs and out-of-network costs in order to determine the estimate and to illustrate to the enrollee the potential cost differential of seeking services out-of-network if that benefit is provided.

Example of Hypothetical Charges row:

This row is necessary to provide an example of what the enrollee's hypothetical cost share would be. Final costs would be dependent upon the applicable deductible, annual maximum amount, and the applicable cost-sharing amount for the provided service based on the benefits of the dental product illustrated in the SDBC.

Summary of What is Not Covered or Subject to a Limitation row:

This row is necessary to ensure the enrollee has a fair estimate and disclosure of the dental product the enrollee is purchasing.

III. DOCUMENTS RELIED UPON

Health and Safety Code section 1363.04.
https://codes.findlaw.com/ca/health-and-safety-code/hsc-sect-1363-04.html

Senate Bill 1008 (Skinner, Stats. 2018, ch. 933, § 2).
https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201720180SB1008

45 Code of Federal Regulations section 147.200
https://www.govinfo.gov/content/pkg/FR-2015-06-16/pdf/2015-14559.pdf

Department of Health Care Services Medi-Cal Dental Provider Handbook (Handbook). First Listed "Full Handbook zip file" pp. first four unnumbered pages, v-vi, 5-106 to 5-126, 13-1 to 13-3
https://www.dental.dhcs.ca.gov/Dental_Providers/Medi-Cal_Dental/Provider_Handbook/

Department of Health Care Services Medi-Cal Dental Services Rate Review October 2019
https://www.dhcs.ca.gov/services/Documents/MDSD/Dental%20Data%20Reporting/2019-Dental-Rate-Review.pdf

Delta Dental:
https://www.deltadental.com/us/en/protect-my-smile/dental-benefits/in-network-dentist-

benefits.html

Covered California Dental Coverage:
https://www.coveredca.com/dental/family/
https://www.coveredca.com/dental/adult-add-on/hmo/

Health Care.gov Glossary
https://www.healthcare.gov/glossary/

Selected definitions:
https://www.healthcare.gov/glossary/annual-limit/
https://www.healthcare.gov/glossary/deductible/
https://www.healthcare.gov/glossary/health-maintenance-organization-hmo/
https://www.healthcare.gov/glossary/in-network-coinsurance/
https://www.healthcare.gov/glossary/in-network-co-payment/
https://www.healthcare.gov/glossary/life-time-limit/
https://www.healthcare.gov/glossary/out-of-network-copayment/
https://www.healthcare.gov/glossary/out-of-network-coinsurance/
https://www.healthcare.gov/glossary/preferred-provider-organization-ppo/
https://www.healthcare.gov/glossary/waiting-period-job-based-coverage/

Federal SBC Template Documents

SBC Template Standard Format: https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/SBC-Template-Accessible-Format-01-2020.pdf

Summary of Benefits and Coverage Completed Example:
https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Sample-Completed-SBC-Accessible-Format-01-2020.pdf

Summary of Benefits and Coverage Instruction Guide for Individual Health Insurance Coverage: https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/sbc-instructions-for-completing-the-individual-health-insurance-coverage-new.pdf

Summary of Benefits Instruction Guide for Group Coverage
https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/sbc-instructions-for-completing-the-group-health-plan-coverage-new.pdf

Simple Fracture Guide: https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Simple-Fracture-Guide-01-2020.pdf

IV. REASONABLE ALTERNATIVES TO THE REGULATION

The Department has determined there are no reasonable alternatives to the regulation.

The Department is mandated to promulgate this regulation pursuant to SB 1008. This bill added section Health and Safety Code section 1363.04 to the Knox-Keene Act and requires a uniform summary of dental benefits and coverage developed for use by the health plans and dental plans regulated by the Department. Furthermore, Health and Safety Code section 1363.04 mandated that the Department and the California Department of Insurance (CDI) enact emergency regulations to implement the statute.

The Department invites interested persons to present statements or arguments with respect to alternatives to the proposed regulations and amendments at the abovementioned hearing or during the written comment period. As part of this process, the Department must determine that no reasonable alternative considered by the agency or that has otherwise been identified and brought to the attention of the agency would be more effective in carrying out the purpose for which the action is proposed, would be as effective and less burdensome to affected private persons than the proposed action, or would be more cost-effective to affected private persons and equally effective in implementing the statutory policy or other provision of law.

V. SUMMARY OF BENEFITS OF THE REGULATION

One of the benefits of the regulation is increasing transparency in the area of dental benefits. This regulation requires health plans and dental plans to provide a summary of dental benefits and coverage for easy comparison and reference for consumers. Currently, health plans do not use a uniform summary of dental benefits for consumers. Other disclosure documents are typically lengthy and complex, making comparison across health plans and dental plans difficult. The requirements of this regulation will assist enrollees by making an easier comparison of dental benefits offered among health plans.

Another benefit is eliminating enrollee confusion and frustration about their dental benefit and out-of-pocket costs. Most enrollees base their choice of coverage on affordability of monthly premiums, access, and out-of-pocket costs. However, when reviewing their current dental plan disclosures, enrollees find it difficult to locate information they need. The Department hopes use of the SDBC will alleviate some of the issues enrollees face today. A SDBC will allow enrollees to easily find information they need to make an informed decision as all SDBCs will be presented in a similar fashion.

VI. ECONOMIC IMPACT

The Department has determined the proposed regulation will not have a statewide economic impact. As required by SB 1008, the proposed regulation establishes a uniform standard dental benefits and coverage summary template for dental benefits that all health care service plans and specialized dental plans must utilize and provide to consumers or enrollees.

VII. ECONOMIC IMPACT ANALYSIS

The Department is mandated to promulgate this regulation pursuant to SB 1008. This bill added section Health and Safety Code section 1363.04 to the Knox-Keene Act and

requires a uniform summary of dental benefits and coverage developed for use by the health plans and dental plans regulated by the Department. The Knox-Keene Act requires that all health plans and dental plans providing dental benefits create a SDBC for consumers and enrollees to facilitate consumers in understanding dental benefits and to allow consumers to compare dental benefits available in the marketplace.

The Affordable Care Act (ACA), under 45 Code of Federal Regulations section 147.200, requires health plans to provide a Summary of Benefits and Coverage to consumers who are previewing health coverage and who are enrolled in health coverage. In adopting SB 1008, the California legislature intended to provide the same transparency for dental benefits as is currently offered in federal law for health benefits.

One of the goals of the ACA is to increase insurance market competition by enabling consumers to compare benefits more completely and accurately. The ACA seeks to improve transparency and comparability in health benefits through the health insurance marketplace and consumer-friendly tools such as the standardized summary of benefits and coverage. The standardized SDBC required under SB 1008 helps consumers make such comparisons between health plans and dental plans regulated by the Department.

All of the provisions within the proposed regulation are clarifying and making specific the requirements of Health and Safety Code section 1363.04. In particular, the proposed regulation provides health plans with the SDBC template and instructions on how to fill out the template, and describes when the SDBC is to be delivered to consumers and how it is to be delivered to consumers. There are no additional requirements for health and dental plans beyond clarifying and making specific the statutory requirements. Health and dental plans subject to the statute may be required to undergo some costs related to updating computer systems, printing costs, or other costs associated with distributing the SDBC to consumers. However, those costs are attributed to the requirement in the statute that health and dental plans provide SDBCs to enrollees and consumers. Therefore, the Department has determined that no additional workload to the Department or health and dental plans exist that are specifically associated with the proposed regulation itself beyond what is required in the statute. The Department has also concluded that any savings a plan may realize following implementation of the regulations would be due to the requirements of the statute, not the regulations.

Creation or Elimination of Jobs Within the State of California

This regulation is designed to assist health plans and dental plans with meeting the requirements of SB 1008 and to enable enrollees to understand their dental coverage benefits. As this regulation would impose no costs or savings to plans, it would not cause plans to create or eliminate jobs. This regulation is designed to help consumers and enrollees easily review and compare the different dental benefits available in the marketplace. When choosing a dental plan, consumers weigh many options, including premium costs and benefits available under a particular dental plan product. Any decisions by consumers following implementation of the regulations that result in plans creating or eliminating jobs would be due to the requirements of the statute, not the regulation. Accordingly, the Department has determined that no new jobs will be created

or eliminated in the state of California as a result of the regulation.

Creation of New Businesses or the Elimination of Existing Businesses Within the State of California

This regulation is designed to assist health plans, dental plans, and enrollees in determining their dental benefit coverage as well as to help the enrollees easily review and compare the different dental benefits available in the marketplace. The dental plan marketplace is competitive within California. When choosing a dental plan, consumers weigh many options, including premium costs and benefits available under a particular dental plan product. Any decisions by consumers following implementation of the regulation that result in creation of new businesses or elimination of existing businesses would be due to the requirements of the statute, not the regulation. Accordingly, the Department has determined the proposed regulation will neither create new businesses nor eliminate existing businesses in the State of California.

Expansion of Businesses Currently Doing Business Within the State of California

This regulation is designed to assist health and dental plans and enrollees in determining their dental benefit coverage as well as to help the enrollees easily review and compare the different dental benefits. The health plan marketplace is competitive within California. When choosing a health plan, consumers weigh many options, including premium costs and benefits available under a particular dental plan product. Any increase in jobs or shift of consumers from one plan to another following implementation of the regulation would be due to the dictates of the statute, not the regulation. Accordingly, the Department has determined the proposed regulation will not result in the expansion of businesses currently doing business within the State of California.

Benefits to the Health and Welfare of California Residents, Worker Safety, and the State's Environment

This regulation is designed to assist health plans and dental plans in complying with the law and to assist enrollees in determining their out-of-pocket costs for dental coverage and to compare the different dental benefits offered by health plans and dental plans. This regulation impacts the health care industry and enrollees.

Accordingly, as described above, the ultimate benefits to health and welfare of residents of California from the proposed regulation are increased protection of the public health and safety through a more transparent disclosure of dental benefits and coverage and providing an easier and more clear process for enrollees to review and understand their dental benefits. The Department does not anticipate this regulatory action will have any impact on worker safety or the state's environment.